

Office of Statewide Health Planning and Development

*California Health Policy and Data Advisory Commission*

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Proposed Minutes  
Health Data and Public Information Committee  
(Joint Meeting of AB524 Technical Advisory Committee and the Health Data and Public  
Information Committee)  
May 15, 2007

The meeting was called to order by Chairperson Jerry Royer at 10:15 a.m., at the Vizcaya Hotel, 2019 21st Street, Sacramento, California. A quorum (defined as 50 percent plus one) was in attendance.

Present:

Howard Harris, PhD, Chair  
Jan Meisels Allen  
Vickie Ellis, RHIT, CHP  
Dorel Harms  
Debra Lowry  
Jacquelyn Paige  
Denis Hunt, RHIA  
Catherine Nichol  
Darryl Nixon  
Teri Smith O'Rourke

Absent:

Santiago Muñoz  
Stephen Clark  
Jay Benson  
Lark Galloway-Gilliam  
Lisa Simonson Mauiro, MSPH, PhD

AB 524 Committee Members:

Jerry Royer, MD, MBA, Chair; Douglas Bagley; Laurie Sobel, JD; Laura Gardner, MD, MPH; Mark Hlatky, MD; Kathy McCaffrey; William S. Weil, MD; Elizabeth Carolyn Abbott; Nancy Donaldson, RN, DNSc

CHPDAC Commissioners:

Vito Genna, Chair; Marjorie Fine, MD; William Brien, MD; Adama Iwu

CHPDAC Staff:

Terrence Nolan, Office Manager



OSHPD Staff: David M. Carlisle, MD, PhD, Director; Elizabeth Wied, Chief Counsel; Beth Herse, Staff Counsel; Michael Rodrian, Deputy Director, Healthcare Information Division; Joseph Parker, PhD, Manager, Health Quality and Analysis Division; Jonathan Teague, Manager, Healthcare Information Resources Center; Candace Diamond, Manager, Patient Discharge Data Section; Starla Ledbetter, Data Management Office; Ginger Cox, Data Management Office; Malika Rajapaksa, Healthcare Outcomes Center; Irene Ogbonna, Patient Data Section

Speakers: Michael Pine, MD, MBA, Michael Pine and Associates; Andrew Bindman, MD, UCSM; Mary Snyder, Sutter Medical Center

Others Present: Chris Menealy, Senior Project Manager, Pacific Project Management; Bruce Furlock, Chair, CHART Steering Committee; LaVonne LaMoureaux, Executive Director, California Health Information Association; Patrick Romano, MD, UC Davis Medical Center

CHPDAC Chair's Report: Vito Genna, California Health Policy and Data Advisory Commission Chair, addressed both the TAC and HDPIC Committees, and explained the procedures pertaining to a joint meeting. The two Committees were to hear the same presentations, and could then comment and ask questions during those presentations, but any action items or motions entertained would be done separately, within the confines of each Committee.

The purpose of the present joint meeting of the AB 524 TAC and HDPIC Committees would be to evaluate the value of additional clinical and administrative elements to be added to the Patient Discharge Dataset, weighing their value against the cost of collection by the healthcare system.

Governor Schwarzenegger has called for greater transparency to enhance healthcare quality and efficiency by expanding and strengthening the ability of OSHPD to collect, integrate, and distribute data. Adding more data elements to the Patient Discharge Dataset will expand the reliability and relevance of the data available for analysis in outcomes reports produced by OSHPD. These outcomes reports encourage healthcare institutions to make quality improvements and support best practices while at the same time informing the consumer's ability to make better choices with respect to doctors and hospitals.

Approval of Minutes: Committee Member Allen made a motion to approve the January 24, 2007 minutes. Committee Member Nichol seconded. The minutes were unanimously approved by the Committee.

OSHPD Director's Report: Dr. Carlisle reported that Maria Giurato has been appointed by Governor Schwarzenegger to be Executive Director of the Health Professions Education Foundation. The Foundation has been without a formal Executive Director from the time Angela Minniefield became Deputy Director of the Workforce Division at OSHPD until Ms. Giurato's appointment.

OSHPD has participated in several constituent meeting held by Governor Schwarzenegger as Healthcare reform continues to go forward. In conjunction with healthcare reform the Governor issued Executive Order SO 607, which calls for increased transparency and quality promotion in healthcare, specifically calling for OSHPD to be strengthened. Dr. Carlisle read the relevant phrase, “to collect, integrate and distribute data on health outcomes, cost, and utilization, and pricing for use by purchasers, health plans, providers and consumers to help inform and drive decision making.”

In 1998, SB 1973 was passed and signed by the Governor. This legislation gave the Office the authority to add additional elements to the discharge data sets collected from healthcare facilities. With only a couple of exceptions, OSHPD has not added additional elements. The addition of new data elements will greatly augment the ability of the data set to enhance quality, transparency in healthcare, and help drive decision making in healthcare in beneficial ways.

OSHPD’s data has resulted in roughly 2,000 health policies, and scientific articles, in addition to being a driving force in healthcare reform discussions taking place throughout the State of California. The data OSHPD collects is important, and OSHPD proposes that expanding and strengthening the data set will greatly enhance the ability to have informed healthcare in the State of California.

#### Update on Healthcare Outcomes Center: Joseph Parker, PhD

Currently a series of DNR analyses are being performed by Mary Tran and staff. This is in response to recommendations regarding revising the heart attack study. There is some disagreement about whether DNR, as a risk factor, should be included in the risk models.

The CCORP Surgeon Level Report for 2002-2004 is currently with the Agency.

OSHPD has an early draft version of the Maternal Outcomes Report ready based on the older '99 through 2001 data. OSHPD wants to make sure the data is updated before the public report goes forward. The most probable timeframe for release of the report is 2008.

Dr. Parker outlined a brief history of the legislation supporting the addition of new data elements to the Patient Discharge Dataset. Active consideration of the data elements began in 1994, and the legislative authority for expansion came with the passage of SB 1973 in 1998.

There were some points in the legislation that were unclear and staff has turned to OSHPD’s legal counsel for clarity. One of those points was what is exempt from the 15 data ceiling that is imposed by the legislation. It was thought that the attachments to the UB04 would be exempt. According to counsel that does not appear to be the case. Only information on the UB04 would be exempt.

Another point not explained in statute is what makes a data element. This appears to be open to interpretation. It may depend on existing standards, how it is recorded at the hospital, and how well OSHPD justifies it. For example, blood pressure might be considered as a single data element because blood pressure is not taken for just the systolic or just the diastolic measure, where a basic blood chemistry panel containing numerous values would be much more difficult to justify as one data element.

Dr. Parker explained that the legislation states that there can be 15 data elements added in any five year period. So, if you add 15 data elements in a five year period and in year 6 you are ready to go with another 15, you could potential add 30 data elements in a 6 year period. Dr. Parker suggested that while listening to the presentations, Committee members keep in mind which clinical data elements would be important for different types of patients and different outcomes, what is feasible given the charge not to impose undue burden on hospitals, and for what data elements do national standards already exist.

Adding New Data Elements to the California Patient Discharge Data Set:  
Michael Pine, MD, MBA

Dr. Pine began his presentation by stating that when considering national standards, California has been a leader in this field, and when considering condition present on admission, California and New York effectively created the national standard.

In considering adding new data elements to the data set, it is important to look at data and decision making as the context. Dr. Pine explained that he looks at data elements not only in terms of information, but how he can best collect the data which is needed by decision-makers. Linking data to decisions is a continuous circle in which:

- Data provides Information
- Information produces Understanding
- Understanding supports Decisions
- Decisions guide Action
- Action invites Evaluation
- Evaluation requires Data

Micheal Pine and Associates produced a study for the AHRQ (Agency of Healthcare Research and Quality) entitled, Adding Clinical Data Elements to Administrative Data for Hospital-level Reporting. One of the objects of the study was to answer the question: How do you create a cost effective data set that is going to provide the information that even the most discerning clinician will accept as valid?

The study looked at a series of risk adjusted models using currently available claims data, and then higher cost items were added sequentially:

- Present-on-Admission Modifier
- Increase Maximum Number of Secondary Diagnoses
- Add Numerical Laboratory Data
- Improve Documentation of Selected Codes
- Add Broad Array of Abstracted Clinical Data

The sources for the data for analysis were 188 Pennsylvania hospitals, OSHPD (Office of Statewide Health Planning and Development) and SPARCS (Statewide System Planning and Research Cooperative System, New York State Department of Health) claims data.

The study looked at mortality across a range of eight surgical and medical conditions which included:

- Abdominal Aortic Aneurysm Repair
- Acute Myocardial Infarction
- Coronary Artery Bypass Graft Surgery
- Congestive Heart Failure
- Craniotomy
- Cerebrovascular Accident
- Gastrointestinal Hemorrhage
- Pneumonia

The study looked at a sequential series of seven different databases with the same analytical technique applied to all of them. The simplest database, ADM-8, was comprised of age, sex, principal diagnosis, eight secondary diagnoses and a few selected surgical procedures which were an indication of severity and complexity, rather than an indication of things that went wrong. The next database, POA-8 was comprised of the ADM-8 plus the present on admission code. The other five databases looked at in the study were:

- POA-24—Same as POA-8 with up to 24 secondary diagnoses
- POA-IC—POA-24 plus secondary diagnoses not included in POA-24 because they were under reported in administrative database but were established as present on admission in clinical database
- Lab—POA-24 plus numerical laboratory data (e.g., creatinine, white blood cell count) generally available in electronic form
- LAB-IC—Lab plus secondary diagnoses not included in POA-24 because they were underreported in administrative database but were established as present on admission in clinical database
- FULL—Lab plus vital signs and lab data not in LAB (e.g., blood culture results) plus key clinical findings abstracted from medical records (e.g., immunocompromised) plus composite clinical scores (i.e., ASA Classification)

After comparing all seven database models, keeping in mind the IOM (Institute of Medicine) domains of quality care: safety, timeliness, efficiency, equity, effectiveness, and patient-centeredness, the conclusion of the study was that present on admission modifiers combined with numerical lab data and improved coding can support accurate, cost effective risk adjustment.

State data organizations have to answer to a growing demand for healthcare accountability and transparency while balancing hospital reporting burden with the public benefit that the information will provide. Dr. Pine's presentation provides evidence that strategic enhancement of existing hospital administrative data with additional select clinical data will improve the validity of risk adjustment by predicting hospitalized patients' risk of adverse outcomes.

Dr. Pine's recommendations for new data elements are:

#### Recommended Data Elements—Linkage, Attribution and Patient Demographics

- Physician Identifier for Interventions
- Unique Universal Patient Identifier
- Identifier Linking Newborn to Mother
- Residence As Indicator of Socioeconomic Status
- Educational Level
- Insurance Coverage
- Primary Language

#### Recommended Data Elements—Clinical

- White Blood Count
- Blood Urea Nitrogen
- Prothrombin Time
- SGOT
- Albumin
- Glucose
- Creatinine
- Pre-Operative ASA Classification
- Other Clinical Data captured with ICD-9-CM codes

#### Recommended Data Elements—Process of Care

- Date and Time of Arrival, Admission, and Discharge
- Date and Time Intervention Begun and Completed
- Date and Time of Special Unit Admission and Discharge
- Admitted for Terminal Care Only

#### Recommended Data Elements—Obtained from ICD-9-CM Codes

- Anemia / Thrombocytopenia
- Hyponatremia / Hyponatremia
- Hyperpotassemia / Hypopotassemia
- Hypoxemia / Acidosis / Alkalosis
- Tachycardia / Tachypnea

- Fever/ Hypotension / Shock
- Coma / Altered Mental Status on Admission
- Obesity / Body Mass Index

Expanding OSHPD's Administrative Dataset: Andrew Bindman, MD, University of California San Francisco

Dr. Bindman stated that the goals of expanding patient-level data are to augment databases to enhance quality and usefulness of data, standardize data elements with other programs at state and national levels, enable linkage with existing datasets, and improve the methodology and databases used for quality assessment analyses, including but not limited to, risk-adjusted outcome reports.

UCSF's role in this process was to create recommendations for expanding administrative datasets through literature review, review of other state's approaches, discussion with data users and providers and consultation with AHRQ.

Some of the limitations of the current administrative data included limited demographic information. While there are variables for age, sex, and race/ethnicity, information such as primary language is not incorporated. This is important and relevant not only with respect to risk adjustment, but also to making assessments about equity and the degree to which different resources are distributed fairly, based on need within California hospitals. There is also limited clinical information that goes beyond administrative codes to understand severity of illness for certain kinds of patients. Additionally there is very limited information on process and timing of care and the lack of certain kinds of identifiers making it difficult to link to other datasets.

The guidelines identified for OSHPD by Dr. Bindman are to first prioritize data elements that support capacity to provide risk-adjusted outcomes that address the IOM domains of quality. The report recommends that consideration be given to the degree to which patient discharge data is empirical data that allows you to address all these domains. The report touched on to what degree data collection can be enhanced to make up for the current deficiencies in the data set with regard to the components of quality: safety, timeliness, efficiency of resource used, equity in terms of fairness of distribution, effectiveness, and patient centeredness; secondly, prioritize data elements for which there are standardized definitions at the national level; thirdly, prioritize data elements that will be useful in evaluating healthcare performance across a range of clinical conditions.

Dr. Bindman summarized the list of possible new data elements that were incorporated in the report entitled "Expanding Patient-level Administrative Data for Quality Assessment" that was prepared for OSHPD:

15 new variables with existing national standards

- Address (geocoded) including codes for homeless
- Initial vital signs (blood pressure, heart rate, respiratory rate, temperature, oxygen saturation)
- Initial laboratory values (hematocrit, white blood cell count, platelet count, serum creatinine, blood urea nitrogen, sodium, potassium)
- Tobacco smoking status
- Time of procedures

Elements that were thought to be exempt at the time the report was prepared but that Dr. Bindman said should have an equally high priority as the 15 listed above.

- Patient primary language
- Time of admission/discharge
- Medical record number
- Mother's medical record number for newborn
- Attending Physician ID
- Operating Physician ID

Dr. Bindman stated that Dr. Pine's report and comments have reinforced that CPAA (Condition Present At Admission) is something that California should be proud of. In this respect OSHPD has provided great leadership at the national level. Dr. Pine's work suggests that much of what will come in terms of improved risk adjustment models will, in fact, come through CPAA.

Dr. Pine's work also suggests that some lab values, and vital signs, can potentially contribute further to improving risk adjustment models. There is no question that this additional data can make some difference at the margin in terms of improving some of the models.

Dr. Pine's summary comments pointed out that there is a very high level of agreement between the expert opinion approach undertaken by UCSF and the empirical evidence, in terms of which data elements turn out to be useful. There is conceptual agreement between Dr. Pine and UCSF that the expansion of data elements should include variables beyond those that would help risk adjustment in terms of clinical variables, to include those that would help to better understand characteristics about the patient, and their social environment which would lead to a better understanding of how fairly resources are distributed, and what attribution is in terms of patient characteristics versus institutional characteristics towards assessment of quality of care.

There is complete agreement with Dr. Pine and UCSF on the clinical elements: white blood count, creatinine, and BUN, and partial agreement on the clinical elements: hematocrit, platelets, sodium, potassium, vital signs and O2 saturation.



There is disagreement on the clinical elements which are almost all localized around the liver: PT, SGOT, albumin and glucose. UCSF considers these to be less routinely tested for and is not convinced of the assumption that if these tests are not ordered the values could be considered normal. Dr. Bindman stated that this raises some issues that need to be considered such as, if lab test are included in risk adjustment models, this may start to drive the testing of patients and that may not be necessary or useful testing. There is probably a substantial pool of people who, if they were measured, would have abnormal values on these measures that did not reach prior clinical attention. Dr. Bindman stated that a lot more “noise” would be introduced into the risk adjusted models by introducing a number of people who are basically clinically well in the area of their liver, but have a slight value outside the range of normalcy, which would have no important predictive power in terms of their outcomes.

*Committee member Donaldson asked Dr. Bindman to explain the discussion around glucose, because she sees that as a quality measure with all the work now being done with glucose management and control, in terms of sepsis and outcomes.*

Dr. Bindman stated that the main point that came up in that context was that glucose might have a narrow application window. Researchers are trying to understand more broadly whether it has a predictive power beyond just looking at conditions like diabetes. It was a judgment call to some extent in terms of what its value might be. Glucose is regarded as potentially quite interesting as diabetes has taken such a prominent role as a public health issue, but it was seen as a little bit too generalizable as compared to CBC or the renal panel.

Dr. Bindman stated that the Pennsylvania study reinforces that routine clinical elements can improve risk adjustment models for outcomes. Additionally, keep in mind that the Pennsylvania study presented here by Dr. Pine did not directly address the value of nonclinical data elements. The Committees should not be discouraged from adding on variables that are not lab values, because adding additional data elements is an opportunity that goes beyond simply addressing marginal increases in the risk adjustment models, it is an opportunity to take a broader view of the degree to which quality can be assessed from the OSHPD Patient Discharge Data.

*Committee member Hlatky commented that smoking is a terrible condition, but that he did not think it was a great for risk adjustment. An alternative would be BMI, which would tell more about a public health issue and actually capture two extremes, malnutrition and overnutrition.*

Dr. Bindman stated that BMI was considered logistically challenging because it requires hospitals to measure how tall patients are and take their weight, two things that are not done consistently across hospitals.

The Collection of Data Elements in a Hospital Context: Mary Snyder, RN,  
Hospital Association

An impact study based on the 21 items identified in Dr. Bindman's Report to OSHPD was conducted to see what they would mean to the data management group that codes these items for inpatient data sets. The goal of the study was to see what would require change, or no change, or would require additional clarification. For example, address is already sent in with a special code identifying the homeless people, so this may or may not require change. But vital signs would require a new process as the data management staff does not currently look at nursing notes or the admission histories. As with vital signs, the coders don't go into lab information systems, or into the nursing notes looking at the lab results, so that would create some change in the process. That would add an estimated three to five minutes per discharge.

Time of procedure and time of admission would require change as the dates but not the times are currently collected.

When looking at change, the impact as well as how that change will happen and how it will be implemented must be considered. The software currently being used for the coding system is MS4. The vendor would need to be involved. Which begs the question, if the change will happen in California only, will the vendor make the needed changes?

There is clarification needed for the physician ID and operating ID. Currently the coders receive an abstract and whether that information would be on the abstract is questionable. That information can be added to the abstract, but the cost must be considered. And primary language is collected at registration, but that is another item that would have to be added to the abstract that adds further to the process.

Many of the data elements being considered would require change, and it could be significant to the hospital and significant to every individual discharge done. Coders try to meet certain productivity deadlines, and all of this could potentially add 6 to 15 minutes which is meaningful to the hospital.

*Committee member Allen asked how long it takes to get outside firms to change their database.*

Candance Diamond, Manager of the Patient Data Section stated that she could not give a specific answer to the question as there were not any real numbers on how long it took various vendors to change their databases in the past.

OSHPD has the authority to give a modification to a facility that needs to work with their vendors to come into compliance and OSHPD has done so in the past to overcome the obstacle of time constraints.

*Committee member Hlatky asked how difficult it would be to add a piece of paper at the front of the chart that listed the 15 data elements to be recorded.*

Mary Snyder replied it would be near to impossible to get them all.

CHPDAC Chairperson Genna explained that is why both the TAC and the HDPIC Committees were created. The HDPIC has a number of Committee members that deal with medical records and collect this type of information. That is why they are asking for clarity as to definitions of what is being collected and need to have an accurate understanding of how difficult it will be to collect.

CHPDAC Commissioner Fine stated that just defining which data element or the number we want is a whole discussion. You have the initial blood pressure or PO2, but that may not be the critical one. You may want the lowest blood pressure or the highest blood pressure, or a patient may come in and develop shocked lung, and so the initial PO2 may be fine, but three days after the ruptured aneurism may be the one you want.

So it is an impossible status to transmit by a simple number for the coders, even the physician coders. The rules have got to be established if you are going to use a single number, and it is very difficult to define what it is you are trying to accomplish.

Committee Member Nixon commented that this whole discussion is going to continue to get pushed nationally, from the government payment side. We are going to be pushed to pay for performance or to pay for improvement. And the consideration is going to be do we have enough of the data elements that we collect to do the risk adjustment that are going to be necessary.

Adding Data Elements: Program & System Impacts: Starla Ledbetter, Data Management Office; Ginger Cox, Data Management Office

As contained in the Health and Safety Code, Section 128737 (d) mandates that data reporting requirements be consistent with national standards as applicable and Section 128738 (a) mandates that advice be sought from the Commission and its appropriate committees and that additions and deletions of data elements are to be made through the regulatory process.

Section 128738 (b) states that prior to any additions or deletions, all of the following shall be considered:

- Utilization of sampling to maximum extent possible
- Feasibility of collecting data elements
- Costs and benefits of collection and submission of data
- Exchange of data elements as opposed to addition of data elements

Section 128738 (c) states that the Office shall add no more than a net of 15 elements to each data set over any five year period and that elements contained

in the HIPAA uniform claims transaction set are exempt from the 15 element limit.

Section 128738 (d) states that in order to minimize cost and administrative burdens the Commission and the Office shall consider the total number of data elements required from hospitals and ambulatory surgery clinics and optimize the use of common data elements.

The following enhancements to MIRCal (Medical Information Reporting for California) were presented:

- Changes to the System Infrastructure—Upgrading hardware and software
- Adding Principal Language Spoken—Standard identified (ISO 639)
- Changes to Present on Admissions Indicator
- Moving Inpatient Data Elements to National Standards—Consistent with ED and AS data
- Accepting ICD-10-CM and ICD-10-PCS
- Adding Clinical Data Elements
- CMS DRG Grouper Changes
- Adding functionality to accept CABG data

*Committee Member Sobel asked a question pertaining to the seven year gap since the passage of SB 680 in 2002 mandating the addition of principal language spoken.*

Candace Diamond, Manager of the Patient Data Section explained that in 2002 OSHPD was also starting the standing up of MIRCal to do the legislatively mandated online submission of all inpatient data. So in weighing our priorities of implementing those mandates, we were standing up, we were designing and paying for MIRCal to get all the online submissions of the inpatient data.

Now that MIRCal is up and running well, we have turned our attention for the last year to principal language and we've been going through the various national standards that are available for principal language. So now we have a standard that seems to meet the needs and seems to be doable by facilities, and we have a regulation package that we have written but have not yet taken to the Director. When we get the regulation package to the Director, we would then present them to these bodies for advice.

#### OSHPD's List of Recommended Data Elements for Consideration by the Committees

Dr. Parker passed out a set of recommendations to the Committees by OSHPD showing the data elements recommended for consideration and the bodies of evidence from which these recommendations were drawn. The list contained clinical data, vital signs and non-clinical data elements in keeping with the larger concept of quality.

Committee Member Donaldson stated that it was her understanding from the information presented that many of the data elements being considered at this meeting for the list of 15 first choice recommendations, would improve the capacity of the Agency, as well as the scientific community to use these for risk adjustment purposes, and it would allow OSHPD to better leverage the outcomes data because more meaningful comparisons could be made between clinical groups. In other words, these are predictive in the precision of modeling for risk adjustment.

Dr. Parker agreed, stating that for the bulk of these that would be the main purpose, but for the nonclinical data elements there are other purposes that they are more commonly used for.

Both the AB 524 TAC and the HDPIC engaged in some discussion and review of the merits and shortcomings of the various data elements proposed for consideration.

#### Motions made by the AB 524 Technical Advisory Committee

A motion was made by Dr. Weil and seconded by Nancy Donaldson, RN. The motion from the TAC committee to the CHPDAC would be to approve the following data elements as the first 15 first priority choices:

- SGOT (AST)
- K (Serum Potassium)
- NA (Serum Sodium)
- pH (blood gas)
- Albumin
- BUN (Blood urea nitrogen)
- White blood cells
- Hematocrit
- Glucose
- Pulse/heart rate
- Systolic/Diastolic Blood Pressure
- Respiration
- Temperature
- Oxygen Saturation
- Geocoded Patient Address

The motion was carried and will go to the CHPDAC as an Action item.

A motion was made by Dr. Weil and seconded by Mark Hlatky, MD. The motion from the AB 524 Technical Advisory Committee to the CHPDAC would be to approve for further consideration the secondary list of choices as presented by staff with the addition of BMI.

The motion was carried and will go to the CHPDAC as an Action item.

Motions made by the Health Data and Public Information Committee

A motion was made by Jacquelyn Paige and seconded by Teri Smith O'Rourke. The motion from the HDPIC to the CHPDAC would be to approve the concept as presented by staff in its entirety for further consideration by the CHPDAC.

This motion was not carried.

A motion was made by Darryl Nixon and seconded by Teri Smith O'Rourke. The motion from the HDPIC to the CHPDAC would be to move the exact items that AB 524 Technical Advisory Committee recommend to go forward for further consideration by the CHPDAC.

The motion was carried and will go to the CHPDAC as an Action item.

The meeting adjourned at 2:43 p.m.

Pending:

1. Present DNR analyses, and discuss whether DNR as a risk factor should be included in the risk models.
2. TAC Committee members requested more frequent updates on the status of items under consideration by the Committee. The Committee requested a meeting be held before the CHPDAC meeting to be held on August 24, 2007.